OTHER PERMANENCY OBJECTIVES GUIDEBOOK

Long-Term Foster Care

Independent Living and Preparation for Adult Living

Self-Sufficiency with Supports

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SECTION I

LONG-TERM FOSTER CARE

Policy

When all efforts to achieve reunification, adoption or legal guardianship are unsuccessful, the objective of long-term foster care may be selected. A planned formal agreement will be entered into by the parent(s), foster family, child and Department.

Criteria for Selection of Long-Term Foster Care Provider

The following priorities will be used by the worker in selecting a potential long-term foster care provider:

1. Relative of the child;

2. Foster parent or another person with whom the child has an existing relationship; or

3. New foster parent who is committed to the long-term foster care plan.

The child's wishes should be considered in assessing any potential provider. The wishes of the biological parent should also be considered, especially when they will maintain contact with the child. The provider should be open to maintaining a relationship with the biological family as outlined in the Long-Term Foster Care Agreement.

Consultation Points

The worker may wish to consult with specially trained adoption staff or the supervisor in difficult cases.

Long-Term Foster Care Agreement

Following the decision for long-term foster care as an objective and the selection of a provider, the worker will prepare an agreement which specifies the worker's and foster parent's responsibilities and the plan for contact between the child and parent(s), sibling(s) and other relatives or significant others.

Status of Agreement

Long-term foster care agreements have no legal standing or safeguards and can be more readily disrupted by the Department or foster parents than can adoption placements or placements with a legal guardian.

Finalization of a long-term foster care agreement does not terminate the court's jurisdiction or the need for regular reviews of the case by the court and worker. Long-Term Foster Care Agreements will be signed by:

_ Biological parents, unless parental rights have been terminated or when the parent(s) cannot be located;
_ Foster parent(s);
_ The child, except children age 13 or younger who may not understand the impact of the agreement or children of any age who are incapable of understanding or signing due to mental disability;
_ The worker;
_ The supervisor; and
_ The designated adoption staff, if appropriate.

Exceptions: If the parent disagrees with the plan, the worker will consult with the county attorney, guardian ad litem and court prior to proceeding.

If a child age 13 or younger objects to the plan, the worker will consider and address the objections. If the objections are not resolved, the worker will consult with the guardian ad litem and determine if long-term foster care is in the child's best interest. The worker will modify the plan, determine the appropriate permanency goal, or proceed with the implementation of the plan for long-term foster care.

The worker will advise the court, parent's attorney and guardian ad litem of the signing of the agreement. See format for Agreement in Forms section of this Guidebook. A copy will be sent to all parties.

Worker Responsibilities

The responsibilities of the worker after the finalization of the long-term foster care agreement include but are not limited to:

1. Consultation with, support, and assistance to the foster family in assuming the primary parenting role and maintaining the child's placement;

2. Assistance to the foster family in preparing the child for adulthood or discharge, including referrals for services, preparation for adult living, and insurance of a family support system;

3. Providing the child with adequate background information about the birth family;

4. Provision of limited supervision of the case, with visits as needed to the foster home, with in-person contact with both the foster parent(s) and child;

5. Consultation with, support and assistance to the birth family in maintaining a supportive relationship with the child;

6. Preparation of court reports and case plans as scheduled;

7. Attendance at court reviews as scheduled; and

8. Arranging and facilitating case conferences, as needed.

Foster Parent Responsibilities

The responsibilities of the foster parent after finalization of the long-term foster care agreement include but are not limited to the following:

1. Assumption of transportation responsibilities;

2. Assumption of day-to-day decision-making, including choice of medical providers;

3. Preparation of the child for adulthood and planning for services which the child will need as an adult; and

4. Communicating to the worker the child's general progress and specific progress including progress toward obtaining the necessary independent living skills.

Contact Between Child and Parent(s)

The worker and foster family will consider the following issues in determining contact between the child and her/his parent(s):

1. Frequency: Determined by the need of child or because of court order. In cases of long-term foster care, and when parental rights are intact, a minimum of contact every three months is recommended, with in-person contact at least once a year. (Because the foster family is to be the "primary family", their requests for holidays take precedence over birth family requests.);

2. Need for supervision if contact with the parent would be traumatic to the child. The court should be advised and options for supervised visits provided to the court;

3. Purpose of the visit. These might include;

    a. Maintenance of family ties and roots, so that the child has knowledge of his/her family when adulthood is reached;
    b. Support for the placement;
    c. Assistance for the foster family, such as respite care, transportation; and
    d. Decision-making for the child;

4. Transportation: The parent should be responsible for arranging and providing his/her own transportation with the foster parent's providing or arranging the child's. The worker should only provide or arrange for transportation when necessary.

Contact Between Siblings

After finalization of the long-term foster care agreement and when siblings are separated, the worker and foster parent should plan for regular contact and visitation between siblings.

Contact Between Child and Other Relatives or Significant Others

Generally the foster parents will decide regarding contacts with relatives or significant others, such as friends or former caregivers. The worker should assist in assessing benefit or harm to the child and his/her need for contact. The worker may override the foster parent's decision based on the best interest of the child. The worker will share her/his reasons for the decision with the foster parents and document them in the child's file.

SECTION II

INDEPENDENT LIVING AND PREPARATION FOR ADULT LIVING

Philosophy

One of the developmental tasks for all children is to prepare for adulthood. This preparation is a life-long process which requires different emphasis at various ages. The child's parents, teachers and other significant adults help the child prepare through informal and formal modeling and teaching. Children who are wards of the Department also need this preparation. The informal and formal teaching may be given by parents, caregivers, mentors, significant others, or community or educational services.

The Department helps children in its custody prepare for adulthood and has specific, more focused services targeted for youth age 16 or older.

The Department will prepare every ward for adulthood and independent living through:

- Participation in decision-making as appropriate;
- Assumption of age appropriate responsibilities; and
- Encouragement of independent functioning based on age and developmental level.

Independent living is:

- a permanency objective; and
- a living arrangement.

Regardless of the permanency objective and living arrangement, case management activities and Preparation for Adult Living Services (PALS) should help wards become self-sufficient adults.

Policy

The Department will prepare every eligible youth for the transition to adulthood by providing services to assist in obtaining self-sufficiency. These services are provided regardless of the youth's permanency objective.

Independent living may be the permanency objective for a youth age 16 or older whose best interest is served by self-sufficiency. A written case plan will include a description of the services and programs the youth age 16-18 receives to acquire the skills necessary for self-sufficiency as an adult. This case plan will be submitted to the court for review.

The parent, worker, youth, caregiver and community and education providers work together to assist the youth in obtaining self-sufficiency.

PART I

General Case Management Activities

The worker will assist wards regardless of age or permanency objective in preparing for adulthood through general case management activities. The worker may use the services described in the Options for Services in Section VI in this Guidebook. The services should be based on the youth's ability and developmental level.

General case management activities include:

- Coordinating services and working with providers to meet the youth's goal;
- Evaluating the effectiveness of services and the continued need;
- Assessing the youth's strengths and needs;
- Helping the youth prepare for discharge or an independent living arrangement.

Services which might assist the youth include, but are not limited to:

- Educational services.
- Vocational rehabilitation.
- Mental Retardation services.
- Advocate for people with disabilities.
- Job Corp.
- National Guard.
- SSI and SSA programs.
- Public assistance programs such as NMAP, AABD, ADC, Food Stamps after discharge.
- College.
- Mentors, community advisors, and job shadowing programs.
- Job Support.
- Housing assistance.
- Former Ward Program (See Service Provision Guidebook, Former Ward Program Section.)

Preparing Youth for Adulthood

All youth age 16 to 18 regardless of permanency objective should have a plan for supporting themselves as an adult. This plan will include the youth's goals for employment, education, financial support, housing, a support system and transportation arrangements.

Case Planning

The worker will include services to prepare the ward for adult living in the case plan for all wards age 16 to 18, whether the ward is living at home or is in out-of-home care. A ward whose goal is independent living will receive a proportionately greater emphasis on these services. The specific case plan will be based on an assessment of the ward's readiness for independent living and the PALS Plan created for all youth who have had the Daniel Memorial Assessment through the PALS program. The outcomes and goals for youth preparing for adulthood are described in Section V in this Guidebook.

The case plan will usually address the ward's full-time participation in academic or vocational training or employment or both geared to self-sufficiency.

Wards who elect to remain in their former foster home or facility past their 19th birthday will be provided with assistance in dealing with their change in status as a result of obtaining majority. This assistance will be provided before their 19th birthday. They and their care provider will be assisted in understanding the young adult's new role as an adult along with his/her responsibility for handling finances as well as other areas of personal decision-making.

Outcomes and Goals for Preparing Youth for Adulthood

The desired outcome for youth with a permanency objective of independent living and youth preparing for adulthood is self-sufficiency. Services to prepare wards for independent living will be directed toward one or more of the goals outlined below. The ward's case plan will include the goal(s) and service(s) selected.

The goals include:

A. Enhanced Self-Esteem. The ward will develop self-esteem, a positive self-image and a realistic confidence in her/his abilities to be successful in independent living; Options to provide services include:

    1. Individual or group counseling by worker, foster parent, or residential staff, therapist or school counselor;

    2. Meetings with former wards who have successfully made the transition to independent living;

    3. Meeting with former wards who have struggled with the transition to independent living;

    4. Participation in a conference for wards in foster care;

    5. Positive feedback from the worker or the involved adults regarding actual accomplishments and strengths; or

    6. A formal assessment of the youth's life skills and strengths.

B. Acquisition of Necessary Life Skills. The ward will have necessary life skills in the following areas:

    1. Locating and maintaining housing;

    2. Home management (food preparation, cooking, cleaning and laundry);

    3. Shopping and effectiveness as a consumer (comparison shopping for clothes, food, household supplies, making a complaint);

    4. Use of community systems and services;

    5. Health care (personal care, family planning, medical assistance);

    6. Money management (handling of finances, budgeting, saving);

    7. Leisure time (recreational and vocational activities);

    8. Personal decision-making (such as problem-solving skills);

    9. Communication skills; and

    10. Understanding of sexual development and family planning alternatives.

Options to provide services include:

1. Individual modeling, teaching by foster parent(s), residential staff, or worker;

2. Participation in life skills training;

3. Supervised practice in the skills listed; or

4. In combination with approaches 1, 2, and 3, use of a volunteer community advisor to assist in application of specific skills.

C. Enhanced Self-Identity. The ward will have an enhanced self-identity by understanding her/his own past and having the documents necessary for self-sufficiency as an adult. Options to provide services include:

1. Use of a life story book to understand past experiences and strengths, and to improve the ward's sense of control over her/his life; or

2. Obtaining of necessary documents such as:

   a. Social Security card;
   b. Birth certificate;
   c. Driver's license, or learner's permit, if appropriate;
   d. School records and diploma or high school equivalency certificate; and
   e. Medical records, including immunization record and history and other documents that are necessary in the transition to independent living.

D. Identifying and Addressing Educational Needs. The ward's educational needs will be adequately evaluated, if this has not occurred previously, and any deficits will be appropriately addressed.

Options to provide services include:

1. Securing educational evaluations for a youth through the local public school district, or other provider, if appropriate; identifying needs, and with the ward's parent, foster parent, or residential staff, developing a plan to address deficits; or

2. Developing with the local school district for wards receiving special education services a procedural agreement regarding the Department's responsibilities and the school district's responsibilities regarding the assessment of the ward's educational needs and development of a plan to address these needs and to assist the ward during the transition to independent living. (Special education students are eligible for services through the public school system through age 21.)

E. Adequate Job or Career Plan. The ward will develop a job or career plan and secure and maintain employment.

Options to provide services include:

1. The use of vocational testing or career assessment tools through the public school district or community college;

2. Participation in individual or group sessions addressing job or career planning and employment-related skills;

3. Participation in specialized or individually developed job training programs; or

4. In combination with approaches in 1, 2, and 3, pairing of a ward with a volunteer community advisor as needed for a one-year period during the ward's transition to independent living.

F. Adequate Support System. The ward will have a support system available to assist in the transition to independent living. The worker, parent, caregiver, mentor/community advisor and others involved will help the ward devise step-by-step plans to achieve her/his goals.

Options to provide services include:

1. Involvement with family or extended family members to maintain and improve relationships between the ward and family members, enhance positive interaction, and aid the family to understand the ward's developmental task and the importance of the family;

2. Involvement with the foster family or appropriate residential staff to maintain and improve a relationship between the ward and the foster family or staff, enhance positive interaction, and aid the foster family or residential staff to understand the ward's developmental task and the importance of continuity of relationships;

3. Identification and maintenance of other supportive relationships between the ward and persons outside the Department; or

4. Assignment of a volunteer mentor/community advisor to aid the ward in making the transition to independent living.

PART II

Independent Living as a Permanency Objective

The worker will use the following criteria in selection of independent living as a permanency objective:

1. The ward is in out-of-home care and reunification, adoption, legal guardianship or long-term foster care has been attempted but efforts have not been successful or this permanency objective is not in the ward's best interest or is no longer appropriate;

2. The ward is capable of caring for himself/herself independently and providing for himself/herself financially;

3. The goal can be reasonably achieved within 18 months of selection;

4. The ward is involved in has a specific plan for full-time or part-time preparation in academic or vocational training or employment geared to self-sufficiency. If a ward has a disability which results in difficulty obtaining employment or prevents maximum

independence or employment, this objective or the objective of self-sufficiency with supportive services should be considered. Both objectives provide an individual plan for the youth to become independent or semi-independent;

5. All services have been provided to the ward and while the ward is not demonstrating good potential for success, she/he is close to the age of majority.

PART III

Services Through the Preparation for Adult Living Services Program

The Department, through the Preparation For Adult Living Services Program (PALS), provides services necessary to assist youth in the custody of the Department in obtaining the skills necessary to prepare for a successful transition to independent living and to prevent long-term dependency on the social services system. Services are offered through the PALS program in five phases:

Phase I. Identification, Referral, Assessment, and PALS planning.

Phase II. Introduction of Skills.

Phase III. Practice Life Skills - Promote Employment and Savings.

Phase IV. Establish Support System and Transition into Independent Living.

Phase V. Aftercare and Tracking.

Phases I - V

The PALS program is designed to assist the case manager in implementing the PALS Plan using a five phase structure.

In order to implement the five-phase PALS program the Department will contract with an outside agency. The agency will hire, train and supervise qualified personnel to assist case managers and eligible youth in carrying out the individualized PALS Plan according to the PALS five-phase program.

Qualified personnel will include 8 PALS Specialists, 1 in each of 6 districts, and two in Omaha. The North Central District will provide the five-phase program through the utilization of PALS providers and care providers. These people will replace the need for the PALS Specialist in the North Central District. The PALS Specialists will work with the youth, worker and others involved to develop and coordinate services for youth participating in the PALS program throughout the phases listed above.

Roles of PALS Program

Role of District PALS Consultant

The District PALS Consultant's role includes the following:

- Providing assistance to the PALS Specialist within the District;
- Reviewing District statistics and reports to monitor the services being provided in their District;
- Serving as a liaison by answering questions and trouble shooting;
- Serving as consultant for Former Ward Program participants.

Role of District PALS Specialist

The District PALS Specialist is the Youth Service System (YSS) contract person in 7 districts and the identified person in the North Central District. The duties include:

- Serving as a resource to the worker on preparing the youth,
- Providing training for the foster parent or provider as needed,
- Serving as a resource to the youth,
- Identifying and/or developing community resources for the youth, and
- Educating the community about the program.

Steps for Preparing Youth for Adult Living

General case management activities as described in Section III Part I are provided for all wards regardless of age. For youth age 16 and older, the following steps should be followed:

Phase I

Referral, Assessment and Case Planning

1. The case manager will refer all youth 15 1/2 of age to the PALS program by using the DSS-80 referral form.

The following codes will be used to classify the case manager's decision on service.

Code "O" - Do not Serve - No Service

Code "1" - Pending - hold until a later date

Code "2" - Begin PALS Services

*For more clarification refer to the PALS procedures Guide Book.

Note: Youth who are 15 1/2 years old or who have a child, may be referred for services.

2. The PALS program prioritizes youth for service based on how close they are to discharge. The PALS Specialist will contact the worker when a youth is scheduled to receive services. Then the PALS Specialist will contact the youth and provider to arrange an assessment date.

3. Following completion of the assessment, a staffing will be held. The staffing should include the worker, youth and the following if appropriate, parent, caregiver, mentor and other providers. This team will develop the PALS plan for the youth based on the assessment. The PALS Plan should include the steps the youth should follow and identify the responsibilities of those who will be assisting the youth in his/her tasks.

4. The worker will adjust the overall case plan to include these goals. The worker will include the PALS Plan in their case plan to be submitted to the court and other involved parties.

Phase II

Introduction of Skills

1. The PALS Plan developed in Phase I will be implemented.

   The PALS Specialist will assist the youth in achieving his/her goals by:

_ identifying and networking with existing community resources,
_ developing resources where none exist,
_ identifying educational and vocational resources, and
_ providing training to develop and enhance the skills of those care providers who are preparing the youth.

   As the youth masters the 4-6 goals identified in the 6 month - to 1 year Pals Plan, other tasks from the assessment should be added.

2. The worker will follow-up with PALS Specialist and youth to see if the youth is complying with the PALS plan. The youth has a responsibility to contact their PALS Specialist on a monthly basis regarding their PALS Plan goals. The worker will update the overall plan and report to the court as required.

Phase III

Practice Life Skills

Promote Employment and Savings

This phase provides the youth with an opportunity for increased independence. The youth will continue to follow the PALS plan while practicing life skills.

1. The PALS Specialist will continue to work with the youth on his/her PALS Plan objectives and encourage preparation for adult living. In the foster care placement, whether that be the foster home, group home, or other living arrangement, the youth should be encouraged to experience shopping independently, preparing meals, doing laundry, arranging his/her transportation and learning to maintain a budget and savings account.

The youth may be employed during this time. If not, the PALS Specialist may assist the youth in setting up volunteer activities or a job shadowing opportunity to acquire the skills and references necessary for future employment.

2. The worker will follow-up with the youth and PALS Specialist periodically to check on progress. New PALS Plan objectives should be added to the PALS Plan as the youth completes others.

3. During this time discussion and exploration for the future movement into an independent living arrangement at the end of phase IV will take place between the youth,

worker, parent or care provider, PALS Specialist and others as identified. This discussion should address housing, education and employment necessary for being self-supportive in the geographic area in which they plan to live. These discussions will help the youth mentally and emotionally prepare for the transition to independent living. Transitional living components should be incorporated into the PALS Plan and youth's case plan by the staffing team. Identification of the plan and responsibilities in writing may be beneficial to all parties. See Phase IV in this guidebook for format.

Phase IV

Establish Support System and Transition into Independent Living

Phase IV will be a continuation of phases I, II, and III. Youth will be reassessed using the original assessment tool focusing on the areas of need identified in the original assessment. The reassessment will identify progress made and areas still needing to be addressed.

1. The transitional living plan components of the PALS Plan will be formalized. This plan will be included in the overall case plan. At this time, the youth will have employment or attend school. The youth will be able to demonstrate the abilities necessary to make the transition. This will include but is not limited to, having a savings account, accumulating basic household goods, plan for transportation, support systems, employment, education and housing.

2. The PALS Specialist will work with the youth and the protective service worker to determine the youth's support system and assist in developing a support system if there is the need. There are two types of support systems available to youth: 1) natural support system, such as, relatives, care provider, significant others; 2) artificial support system, such as, community advisor or volunteer mentor which will be developed by the PALS Specialist. The PALS Specialist will be responsible for development of support systems only in the district they are working in. If the youth will be moving to another area in the State which is covered by a PALS Specialist, that specialist will be contacted and become responsible for the development of the needed support system and services.

During the development of the artificial support system, the PALS Specialist will be responsible for recruitment, screening, matching, ongoing training and supervision. The PALS Specialist will follow the procedures as outlined in the Department's Volunteer Mentor Handbook.

3. The worker will monitor and supervise the youth as identified in the PALS Plan. The worker and PALS Specialist will work together to prepare the youth. Both will identify with the youth a target date for the move into an independent living arrangement. Ample time (3-6 months) should be given for the youth to prepare for the physical move into his/her independent living setting.

4. Prior to the actual move, the PALS Specialist will interview the youth to obtain a baseline for a tracking system, using a Department developed and approved questionnaire.

Phase V

Aftercare Services and Tracking

This phase is for youth who are age 16-21 and living independently. The youth will receive aftercare services from the PALS program as needed. This phase provides for: 1) an evaluation period, 2) support services, 3) aftercare services and 4) a tracking component.

Services

The PALS program will monitor the youth during a 6 month stabilization period. During the stabilization period the PALS specialist is responsible for monitoring the established support system and providing aftercare services for each youth. These services may include but are not limited to the following: 1) financial management counseling, 2) advocacy in the workplace, 3) emotional support systems, 4) further development of problem-solving skills, 5) and aftercare up to the age of 21 for all youth who are referred, as long as they have been a state ward after the age of 16.

The youth is responsible for maintaining goals identified in the PALS Plan. The achievement of these goals will result in a more self-sufficient young adult. Youth who are in the Former Ward Program will receive special assistance to enhance their level of success in the educational setting.

Tracking

The tracking component will be administered at exit of care, six-month, one-year and two-year intervals by the PALS specialist. The information gathered in the interviews b the Specialist will provide an opportunity to identify needs and address them with the youth through the aftercare component.

In the event that the youth does not have a worker, the PALS Specialist will discuss aftercare plans and goals for the youth with the District Consultant.

Financial Arrangements for Wards in Independent Living Arrangements

The PS and IMFC workers should determine the youth's payment. A payment of up to $351 may be made to or on behalf of a Department ward in an independent living situation based on the written plan developed by the PS worker. Normally payment is made to the ward; however, the service plan may specify that a portion of the payment is paid to a landlord, using Forms DSS-5 and DAS 02-09. The IMFC worker and the protective service worker should work together on the budget for the youth. The following information is provided as a reference for PS workers.

The ward is allowed a $90 work allowance from any earned income. With the exception of disregarded income listed in 479 NAC 2-001.11A4, all earned and any unearned income must be used to meet the ward's needs. The IMFC worker uses the Form IM-26FC to compute the payment. (Form IM-26FC is in the Forms Section of this Guidebook.)

The following expenses are considered in determining payment:

1. Clothing;
2. Housing;
3. Transportation;
4. Food;

5. Savings;

6. Educational needs; and

7. Personal needs.

Rent Payment: With supervisory approval, the PS worker may authorize a one-time vendor payment for a rent deposit and/or one month's rent for a Department ward who is preparing for independent living. The rent deposit must not exceed $210. (479 NAC 2-002.01F1)

Living in a Dormitory: If a Department ward is going to school and living in a dormitory, the Department pays the dorm fees, including a deposit, either directly to the school or to the ward. The ward may receive a grant of $100 maximum for his/her other needs, including meals that are not provided by the dorm. To determine the grant amount, the IMFC worker completes Form IM-26FC, showing shelter and food costs as expenses and the monthly amount for dorm fees as unearned income. (479 NAC 2-002.01F2)

Case Closure

The worker will inform the PALS Specialist when the youth is preparing to live independently or leave the system. Services may continue through the PALS Specialist after discharge. (See Independent Living as a Permanency Objective, Phase V this Guidebook.)

The worker will close the case as outlined in the Case Management Guidebook, Case Evaluation and Case Closure Sections.

Transitional Living Plan

Youth preparing for an independent living arrangement or adulthood will have a plan which lists components necessary for living independently. This plan should include but not be limited to:

1. Clearly stated responsibilities of the ward, the worker and other parties;

2. The education, training and work plan that will provide full-time activity for the ward;

3. The plan for assisting the ward in developing her/his life skills and other appropriate objectives necessary for a successful transition to independent living;

4. The plan for monitoring and supervision of the ward including the frequency of contact by the worker, volunteer mentors/community advisors and others;

5. The anticipated length of time support services and payments will be needed until the ward is fully independent;

6. The financial plan for the ward including the financial responsibility of the ward and the Department and a statement of how the Department's portion will decrease unless the ward continues in school and target dates for these adjustments;

7. Identification of a support system; and

8. If appropriate, a statement regarding possible consequences if the ward does not adhere to the agreement.

SECTION III

SELF-SUFFICIENCY WITH SUPPORTS

Policy Statement

Policy states that self-sufficiency with supports is an appropriate permanency objective for a youth who experiences disabilities who currently is receiving and will continue to need a living situation with supports as an adult. Ward's may require continuing involvement with the Department or another service agency or both after discharge from the state ward system.

Purpose

The purpose of the self-sufficiency permanency objective is to provide the protective service worker with a realistic goal when the youth currently requires and will continue to need a living situation with supports as an adult. These living situations with supports will typically include, but not be limited to: family home, apartment with supports, room and board homes, center for developmentally disabled, licensed domiciliary facility, certified adult family home, licensed residential care facility, licensed group home for children or child caring agency, or nursing facility.

Protective Service Worker Activities

In addition to regular case management activities, a significant amount of the protective service worker's activities in regard to children with the self-sufficiency objective will involve:

- Referring to specialty professionals and other agencies with expertise in the particular disability (for example, mental retardation, mental illness, specific physical problem).
- Coordinating assessment and planning processes for the ward on a periodic basis (at least annually).
- Provide information and referral services regarding available services.
- Securing needed services based on assessment and plans in a timely manner.
- Obtaining guardian limited guardian, protective payee or conservator for ward, as needed.
- Discharge planning with ward, others significant to the ward, and professionals for transition to adulthood.
- Referral to Mental Retardation (MR) Waiver Programs or the Aged and Disabled Medical Waiver.

Collaboration and Planning

The protective service worker will work with other professionals when the ward has an emotional or mental illness, behavioral impairment, physical disability, development disability, mental retardation, or any combination of these which require special assistance, support or services to meet the child's needs.

These professionals may include but are not limited to: special education or other education representatives, disability specialist, medical personnel, foster parent or assisted living representative, support provider (agency or individual) or job or vocational training staff.

The purpose of working with these others is to determine the child's strengths and needs and develop a plan. It is desirable to develop one plan for coordinated services. The Individual Education Plan (IEP) planning process is conductive to this kind of collaborative planning. Whenever possible, all planning should be incorporated in to the IEP. (See Section II, Preparation for Adulthood of this Guidebook.) The team made up of the protective service worker, the child, surrogate parent, parent and caregiver, and other professionals with expertise in the disability area will determine whether or not the child will require a supported living situation based on the child's needs.

Considerations for Services to Wards

Children with the permanency objective of self-sufficiency have special considerations due to their disability(s). The following considerations may be helpful in working with these children:

- Children with disabilities in out-of-home placement have the same right and need to a permanent living status as do all children in care;
- Each child with a disability is to be maintained in the most appropriate environment based on the strengths and needs of the child;
- The environment and program for the child with a disability should offer normal supports, dignity and respect to assist and support him/her in being as independent as possible.

Referrals

Linking the youth with the most appropriate referral source is essential to ensuring the optimum for the youth and his/her future. If a referral has not been made to one of the following referral sources, as indicated by the youth's circumstance, then one should be made to one of the following (and others as indicated by the child's needs):

- Community-Based Developmental Disabilities/Mental Retardation Programs.

The protective service worker will make a referral for wards with developmental disabilities including mental retardation to the appropriate community-based developmental disability/mental retardation program by contacting DPI's services coordination for determination of eligibility and service delivery as appropriate. The protective service worker should periodically follow-up with the worker assigned to make sure that coordination of services is occurring and to advocate for the child and family as needed.

If a youth is not receiving services from the community-based mental retardation program, the protective service worker will need to consult with the community-based developmental disability program when the ward reaches the age of 14 (or at the time of admission to the program if the child is made a ward and is 14 or older) to develop a vocational plan and evaluate the child's potential needs for services as an adult.

- Beatrice State Developmental Center (BSDC).

BSDC is operated by the Department of Public Institutions and may provide services through the Center's Outreach Treatment Service (OTS) and the inpatient Intensive Treatment Service (ITS).

Services provided include:

- Providing to families and community-based agencies, expert behavioral or psychological consultation, staff training or family therapy to prevent unnecessary inpatient placement through the OTS;
- Providing intensive short-term treatment for those youth with behaviorally-impairments and mental retardation whose needs cannot be met by their families or community services through the ITS;
- Providing follow-up services to maximize successful community-based placement through the ITS and OTS.
- Referral to other community and Department services.

The worker will need to determine if the child would benefit from referral to other community and Department services and refer the child or family when appropriate. The worker will need to act as an advocate to ensure the child and family receive all needed services.

- Education related services.

If a worker believes a youth is in need of special education services, a referral should be made to the public school district. Special education services can continue through the school year in which the youth turns 21.

Public schools offer a transitional program for youth verified for special education. The school is to develop a formal transitional plan starting when a youth is age 14 to plan for the transition to adulthood. These services may continue through the end of the school year in which the youth turns 21. There are Transitional Specialists in school districts across Nebraska. If a worker is unsure of who that is, contact the school district or the Department of Education, Special Education Department in Lincoln at (402)471-2471.

If a student who is receiving special education services is approaching age 18 and the surrogate parent is recommending termination of special education services, the worker may wish to contact an advisory group on behalf of the youth.

- Medicaid Waiver for Children with Mental Retardation and Related Conditions.

This program provides an array of in-home supports or community placement for children under 21 with developmental disabilities. These services include: habilitation, transportation, homemaker, respite care, environmental modifications, habilitative day care and case management.

- Medicaid Waiver For Adults with Mental Retardation and Related Conditions.

This program funds habilitative services in communities for adults (21 and over) who would otherwise require institutional services.

- Aged and Disabled Medical Waiver.

This option allows clients with care needs to choose in-home support services as an alternative to institutionalization. If a needs assessment determines a person requires nursing facility care, then, under the provisions of this waiver, she/he may be eligible for in-home support services if she/he can be safely served at home at a cost not more than Medicaid would pay for nursing home care. Medicaid services available under this waiver are: chore services, adult day health care, day care for children with disabilities, independent living skills, respite care and transportation.

- Vocational Preparation.

When a ward with a disability reaches age 14 (or at the time of commitment if the ward is 14 or older), the protective service worker will need to work with others to establish a vocational preparation plan in collaboration with the family, child, school district, and other service providers. The formal Transitional Plan to Adult Living through the school districts should be used for special education students.

SSI Payments

When a protective service worker believes that a ward with a self-sufficiency permanency objective is eligible for SSI (Supplemental Security Income through the Federal government's Social Security Administration) the worker should work with the IM worker, youth and family to complete an application for SSI benefits on behalf of the youth. The worker will forward appropriate information to the IM worker in order to process the application. (See 469 NAC 2-007.03 ff.) If the youth's application is denied, the worker should re-apply. It may take three applications before disability eligibility is determined.

If the youth or his or her parents are already receiving SSI payments, then a change of payee form with the Department as the new payee must be completed when a ward enters out of home care.

Payments from SSI are placed in the ward's guardianship account if the amount exceeds the cost of the youth's care. When the youth is leaving the system, a payee may be needed for the SSI payment.

Guardianship

When a youth reaches the age of 18, the worker, in conjunction with the child's family and/or others significant to the child, will assess if the child is able to manage his/her affairs or is able to make, communicate, or carry out responsible decisions concerning himself/herself in areas such as the following:

- Selecting a residence;
- Arranging for medical care;
- Protecting his/her or her personal effects;
- Giving necessary consents, approvals or releases;
- Arranging for training, education or other habilitative services;
- Applying for private or government benefits for which he or she may be entitled;
- Instituting proceedings to compel persons liable for his/her support to support him/her;
- Entering into contracts; and
- Receiving money and property and applying it to expenses, training, education and habilitative services.

If any of these areas indicate that the ward is in need of a guardian or conservator, the protective service worker should provide assistance in this regard. (See 465 NAC 2-008 for information on appointment of a protective payee, limited guardian, guardian or conservator, and 473 NAC 5-015 for information on Adult Protective Services)

Statutory Reference: Neb. Rev. Stat. 30-2620.

Discharge Planning

Discharge planning establishes a smooth transition from wardship to community living. Effective discharge planning will ensure that needed supports are in place while recognizing the strengths and needs of the ward.

Because the objective of self-sufficiency means that the ward will continue to require a supported living situation into adulthood, it is essential that the protective service worker plan how the ward's needs will be met once the youth's protective service case is closed due to reaching the age of majority. This planning should involve the ward to the maximum extent possible, those who are significant to the ward, and other professionals. The plan should reflect the needs of continuity of any programmed services (for example, educational and vocational services), maintaining significant relationships, and future case management. The Transitional Plan to Adult Living through the school district should be used for those receiving special education services.

The protective service worker will need to time these activities to coincide with the ward's reaching the age of majority (age 19), and then close the case (See Case Management Guidebook, Case Evaluation and Closure, and Discharge of Ward Sections).

LONG TERM FOSTER CARE AGREEMENT FORMAT

The persons involved in this agreement believe that it is in the best interest of (CHILD'S NAME) that he/she be allowed to remain in the home of (NAME OF FOSTER PARENTS(S)) and be raised by them as a member of the family until he/she reaches adulthood.

1. I/We _____, foster parent(s) of (CHILD'S NAME) agree to be the primary parent(s) for this child until he/she reaches adulthood. I/We will not ask for him/her to be removed from our ho except under serious, unusual circumstances. I/We agree to share information with the Department of Social Services and with the biological parent(s), _____.

2. We, the Nebraska Department of Social Services, agree to maintain and support the long-term foster care placement of (CHILD'S NAME) in the foster home of _____. We will not disrupt this placement except under serious, unusual circumstances and only then will the discussion of the foster family and in the best interest of this child. The Department of Social Services will provide foster care payment, medical services and other support for the care of (CHILD'S NAME) through the foster care program.

   The Department of Social Services, foster parent(s) and biological parent(s and this child will develop a visitation plan for (CHILD'S NAME) Court approval is required for the visitation plan. The Department will use the plan to the court. As of this date, the plan for contact between (CHILD'S NAME) and (PARENT(S) NAME) , siblings or other relatives or significant others is as follows:

   This plan may be modified based on (CHILD'S NAME) needs or request of a person involved in this agreement. The Department will advise the court of the modification.

3. I/We _____ the biological parent(s) of (CHILD'S NAME) agree that he/she should remain in the foster home of (FOSTER PARENT(S)) until he/she is an adult. I/We will keep the Department of Social Services and (FOSTER PARENT(S) advised of my/our whereabouts an keep a regular schedule of visitation as stated above. I/We will pay _____ per month toward (CHILD'S NAME) support.

4. I (CHILD'S NAME) understand that I will remain in the foster home of _____ because I want to be part of this family until I am on my own and self-supporting.

Signed: Date.

_____
(CHILD)

_____
(FOSTER PARENT(S)

_____
(BIOLOGICAL PARENT)

_____
(BIOLOGICAL PARENT)

_____
(WORKER)

_____
(SUPERVISOR)

_____
(DESIGNATED ADOPTION STAFF (if appropriate)

_____

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